Expanding Access to Care

Calvert Crisis Response and Mobile Crisis Service Programs

Denise Dickerson, MS, LCADC, LCPC
Jason Phelan, BA
Drew Fuller, MD, MPH, FACEP

Calvert Crisis Response
Calvert County Health Department
www.CCBHCrisisResponse.org

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Decrease in Opioid OD Deaths

- Calvert County 20% **decrease** in 2020 (from 2019)
- National Increase 2020
- Maryland 19% **Increase 2020**

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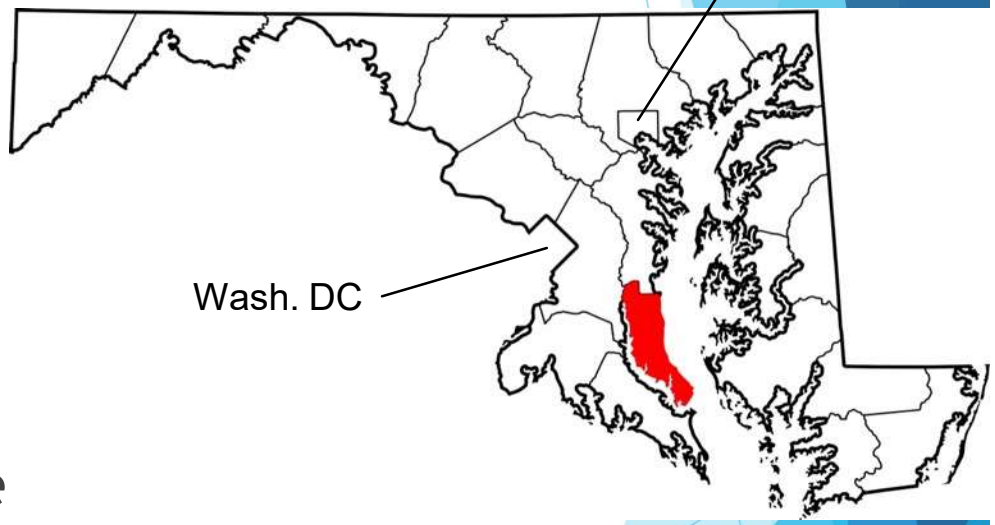
*OOCC Dec 2020 Report

Calvert County, Maryland

- Rural/Commuter Community
- 30 miles Southeast of DC
- Population 100,450
- Volunteer & Prof. EMS
- 1 Hospital (74 beds)
- Health Dept. w/ Behavioral Health Services
- Approx. 500 OUD patients unde management



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Common SUD Engagement Models

- Delays in care by days to weeks
- Look for appointment space for a “Complete Assessment”
- Front-loaded approach
- Restricted processes
- Limited hours and location of service

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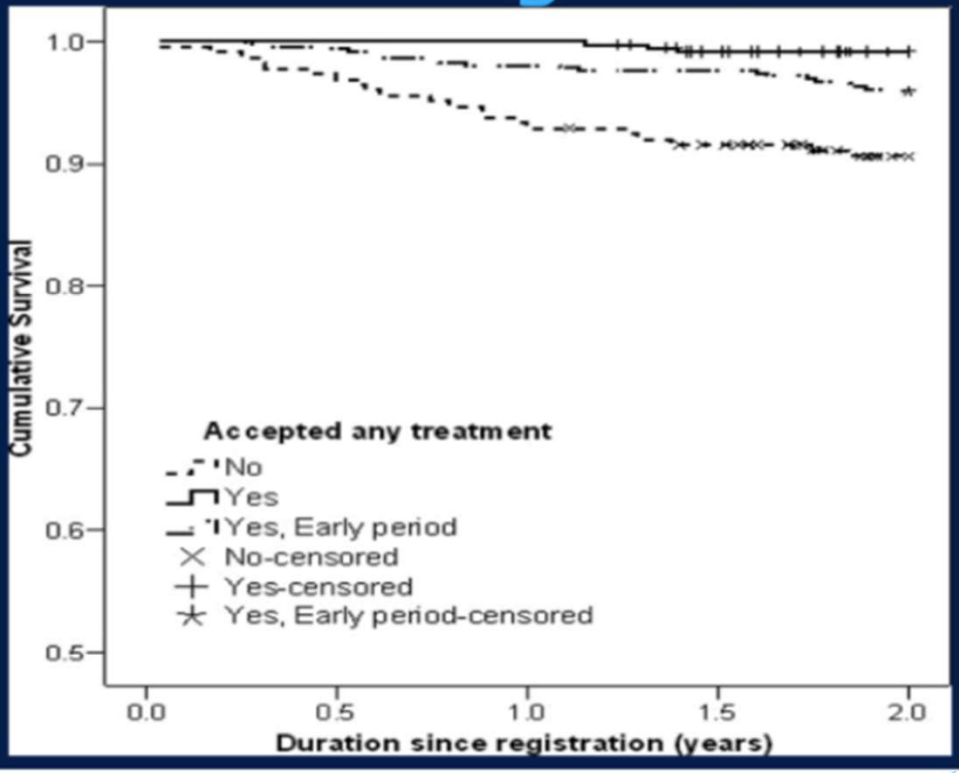
The Problem

People Die Waiting for Treatment



Peles et al. J Addict Med 2013;7: 177–182

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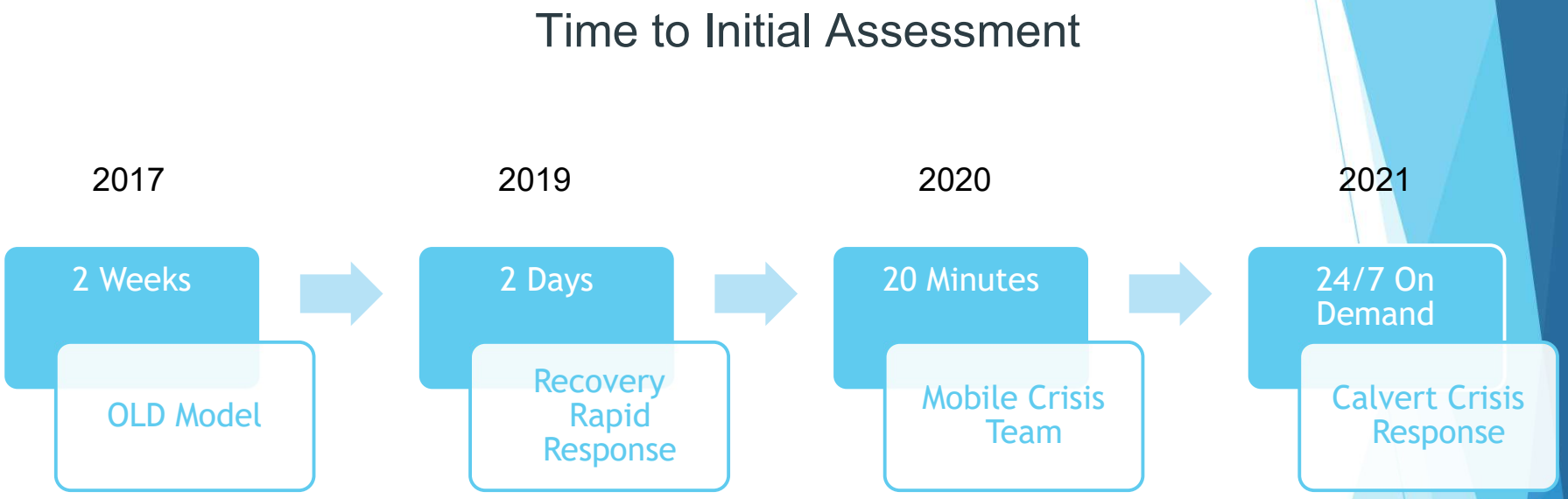
Treatment Model Evolution



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Treatment on Demand Model

- "Immediate" evaluations
- EARLY medication
- Team-based
- Client-centered
- Expanded hours
- Close follow up appt.
- Case management
- Offer additional services

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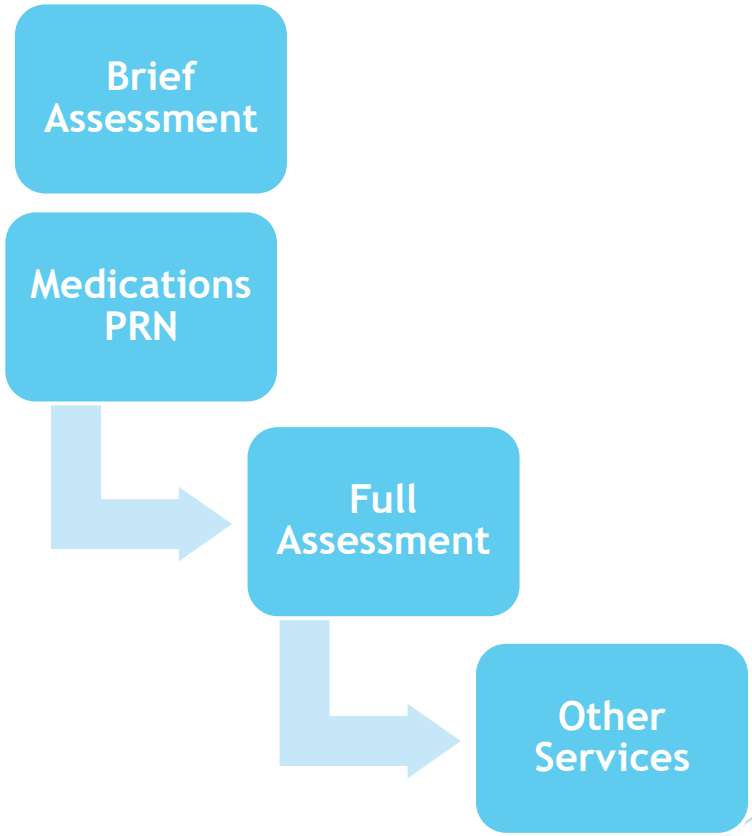
Progressive Evaluation Process

Calvert Crisis Response



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Treatment Locations

Office

Mobile Unit

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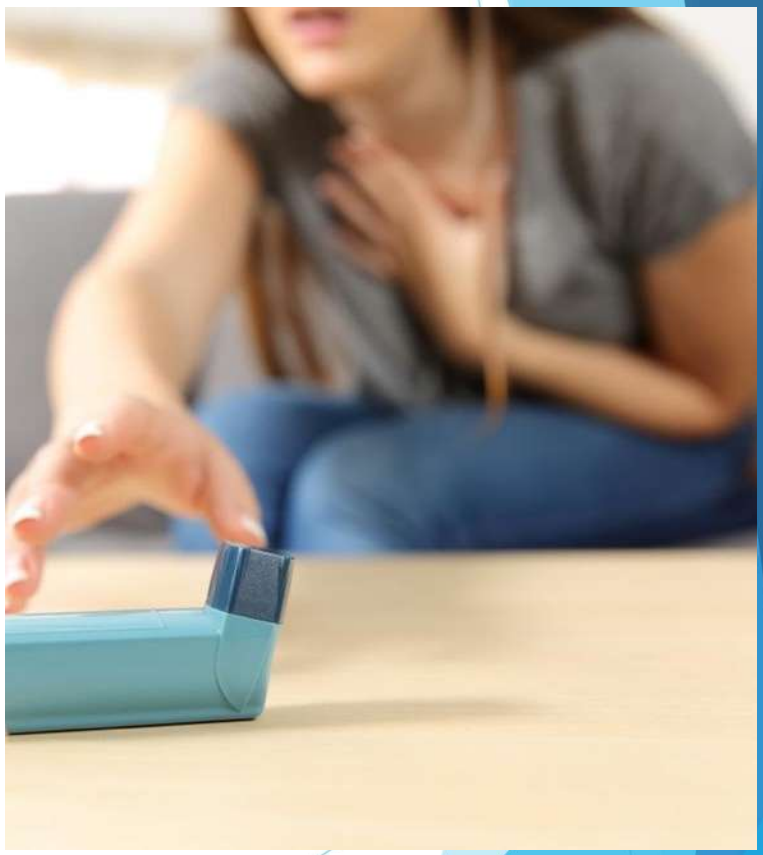
Prompt Medical Treatment

- First thing first
- Allows us to advance care
- Patient-centered
- Stabilizes
- Improves engagement
- Improves follow up



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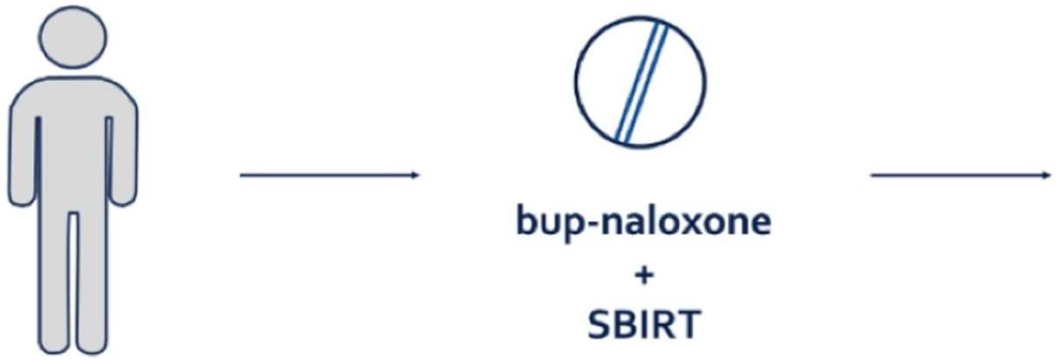
Emergent MAT Improves Treatment Success



D'Onofrio G, JAMA 2015

Medications On-Site

- Distinct advantages
- Important for withdrawal management and induction
- Use of symptomatic meds

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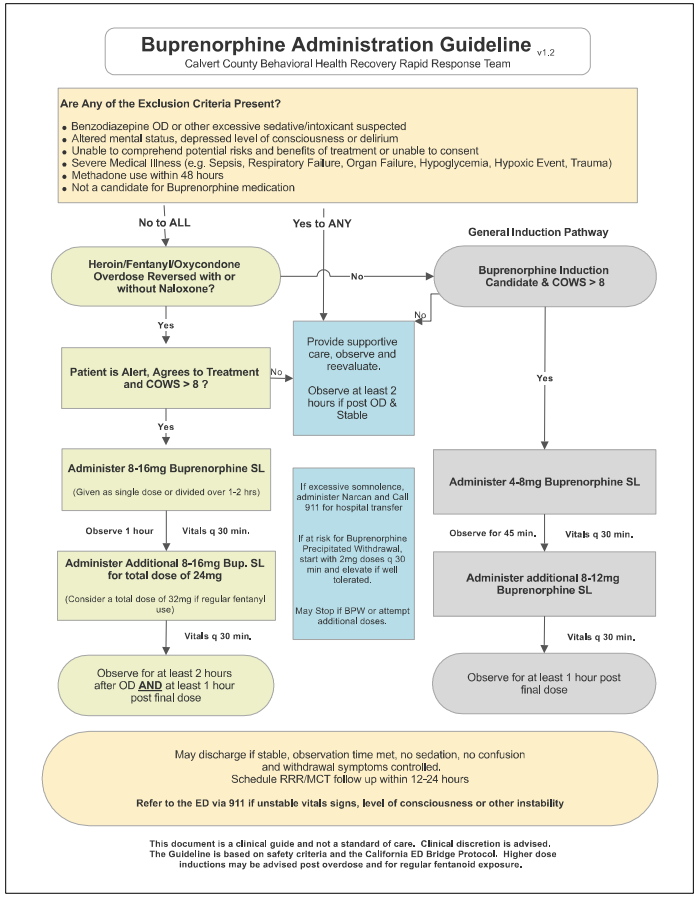
Office Induction Guide



Buprenorphine Administration Guideline v1.2

Calvert County Behavioral Health Recovery Rapid Response Team

Are Any of the Exclusion Criteria Present?

- Benzodiazepine OD or other excessive sedative/intoxicant suspected
- Altered mental status, depressed level of consciousness or delirium
- Unable to comprehend potential risks and benefits of treatment or unable to consent
- Severe Medical Illness (e.g. Sepsis, Respiratory Failure, Organ Failure, Hypoglycemia, Hypoxic Event, Trauma)
- Methadone use within 48 hours
- Not a candidate for Buprenorphine medication

No to ALL

Heroin/Fentanyl/Oxycondone Overdose Reversed with or without Naloxone?

Yes

Patient is Alert, Agrees to Treatment and COWS > 8 ?

Yes

Administer 8-16mg Buprenorphine SL

(Given as single dose or divided over 1-2 hrs)

Observe 1 hour — Vitals q 30 min.

Administer Additional 8-16mg Bup. SL for total dose of 24mg

(Consider a total dose of 32mg if regular fentanyl use)

Vitals q 30 min.

Observe for at least 2 hours after OD **AND** at least 1 hour post final dose

Yes to ANY

No

Provide supportive care, observe and reevaluate.

Observe at least 2 hours if post OD & Stable

If excessive somnolence, administer Narcan and Call 911 for hospital transfer

If at risk for Buprenorphine Precipitated Withdrawal, start with 2mg doses q 30 min and elevate if well tolerated.

May Stop if BPW or attempt additional doses.

General Induction Pathway

Buprenorphine Induction Candidate & COWS > 8

No

Yes

Administer 4-8mg Buprenorphine SL

Observe for 45 min. — Vitals q 30 min.

Administer additional 8-12mg Buprenorphine SL

Vitals q 30 min.

Observe for at least 1 hour post final dose

May discharge if stable, observation time met, no sedation, no confusion and withdrawal symptoms controlled.
Schedule RRR/MCT follow up within 12-24 hours

Refer to the ED via 911 if unstable vitals signs, level of consciousness or other instability

This document is a clinical guide and not a standard of care. Clinical discretion is advised. The Guideline is based on safety criteria and the California ED Bridge Protocol. Higher dose inductions may be advised post overdose and for regular fentanoid exposure.

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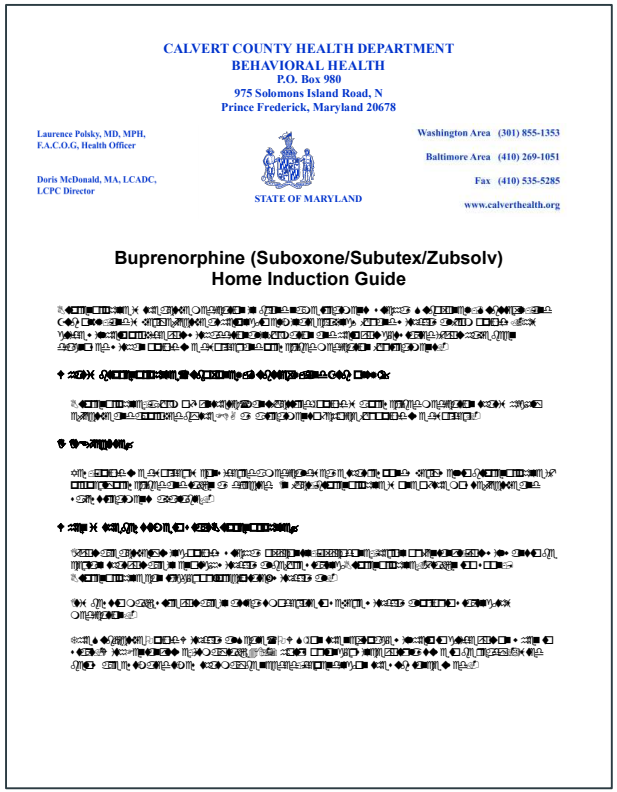
Home Induction Guide



CALVERT COUNTY HEALTH DEPARTMENT
BEHAVIORAL HEALTH
P.O. Box 980
975 Solomons Island Road, N
Prince Frederick, Maryland 20678

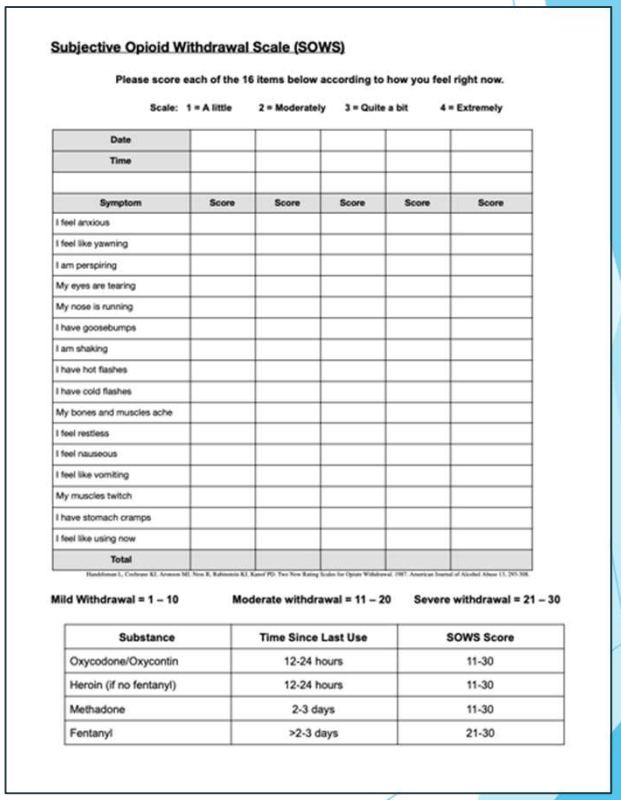
Laurence Polsky, MD, MPH,
F.A.C.O.G, Health Officer

Doris McDonald, MA, LCADC,
LCPC Director

STATE OF MARYLAND

Washington Area (301) 855-1353
Baltimore Area (410) 269-1051
Fax (410) 535-5285
www.calverthealth.org

Buprenorphine (Suboxone/Subutex/Zubsolv)
Home Induction Guide



Subjective Opioid Withdrawal Scale (SOWS)

Please score each of the 16 items below according to how you feel right now.

Scale: 1 = A little 2 = Moderately 3 = Quite a bit 4 = Extremely

Date					
Time					
Symptom	**Score**	**Score**	**Score**	**Score**	**Score**
I feel anxious					
I feel like yawning					
I am perspiring					
My eyes are tearing					
My nose is running					
I have goosebumps					
I am shaking					
I have hot flashes					
I have cold flashes					
My bones and muscles ache					
I feel restless					
I feel nauseous					
I feel like vomiting					
My muscles twitch					
I have stomach cramps					
I feel like using now					
Total					

Handelsman L, Cochrane KJ, Aronson MJ, Ness R, Rubinstein KJ, Kanof PD. Two New Rating Scales for Opiate Withdrawal. 1987. American Journal of Alcohol Abuse 13, 293-308.

Mild Withdrawal = 1 – 10 **Moderate withdrawal = 11 – 20** **Severe withdrawal = 21 – 30**

Substance	Time Since Last Use	SOWS Score
Oxycodone/Oxycontin	12-24 hours	11-30
Heroin (if no fentanyl)	12-24 hours	11-30
Methadone	2-3 days	11-30
Fentanyl	>2-3 days	21-30

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Medication Security

Medication Tracking System

Medication Storage

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Medication Security

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Mobile Crisis Team

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Peer Recovery Specialist

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Licensed Counselor

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Physician / Nurse Practitioner or Nurse (Telehealth)

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"Meet Them Where They Are"

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Customized Treatment Van

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Clinical Treatment Area (Front Room)

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Clinical Treatment Area (Back)

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Features

Awning

Generator

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Labeling

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Activation of the Team

911

CONTACT
RECOVERY RAPID RESPONSE
AT

877-467-5628

7 DAYS A WEEK

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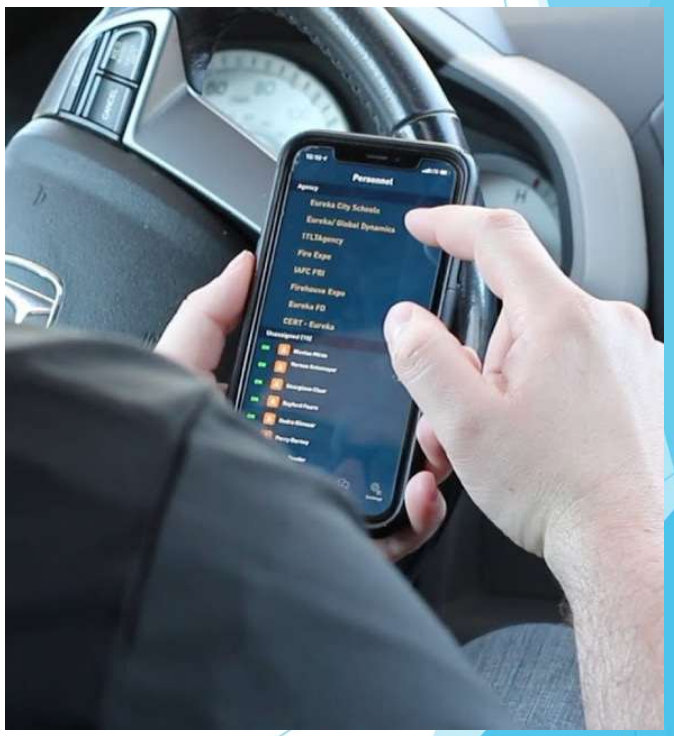
Activation Tools

EMS/Police Radio

Active911 App



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Scene Interaction

- Stage-back until cleared
- Engage patients & families/others
- Transport to Health Dept. PRN
- Interact with Police/EMS personnel
  - Consult/Collaborate
  - Provide Narcan kits

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Mobile Prescribing

- Easy to do via EHR
- Convenient
- Client-centered
- Close to pharmacies
- Can help transport
- Challenge with after hours
- Can bring to the office for dosing if available

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Why No Mobile Administration

- Approved by our State agency

BUT

- **No DEA provision for MOBILE ADMINISTRATION**

  (Policy head & General Counsel)

- Requested "Specialty EMS" designation in final comment for forthcoming DEA regulations ??

- May be option for "Dispensing" several days (future regs)

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Community & Stakeholder Engagement

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Get Their Attention

Anyone is Vulnerable

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Real People

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Real People

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Stigma Awareness

The Great Threat

STIGMA

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EMS Leadership Collaboration

- Communication when activated
- Waiting on scene if MCT en route
- Transitioning stable patients that decline transport to the hospital

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EMS & Law Enforcement Messaging

- Improving patient engagement & outcomes
- Decreased turn around times
- Decreased repeat calls
- Optimizes resource use

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Addiction & Service Education

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Addiction & Service Education

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Hospital Collaboration

- ED and HD communication
- Peer Recovery Program
- MCT can be called to ER
- Quick Referral & Follow Up
  - Same day / Next day
  - 24/7

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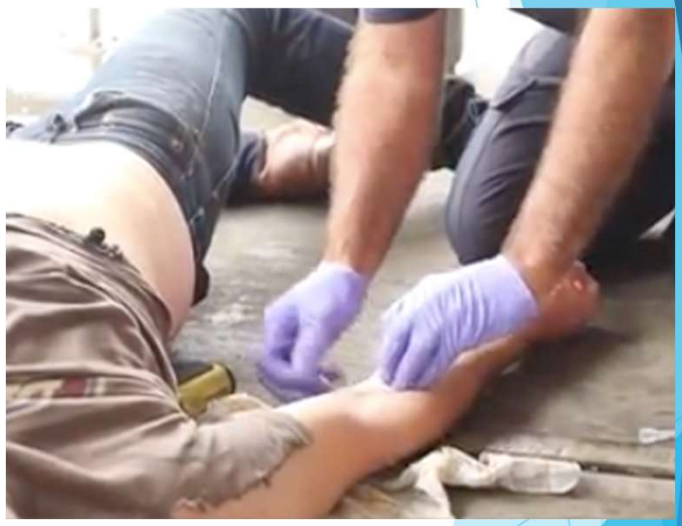
Addressing Compassion Fatigue



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Community Provider Collaborations

- Crisis beds
- Local and regional residential programs
- Local outpatient treatment programs
- Local community-based advocacy groups

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Community Partner Collaborations

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Community Outreach

- Help spread the word
- Window clings
- Business cards
- Other signs
- Formal collaborations

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Referral / Info Cards

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Advertising

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PR - Collaborators

TRENDING TODAY

Hospital, County Mount Robust Effort to Tackle OPIOID ABUSE

Task Force Works to Turn Tide on Overdose Deaths in County

Even before there was a national opioid crisis, CalvertHealth Medical Center took the lead in forming a multidisciplinary task force with its community partners to tackle the problem comprehensively. CHMC's reliance on evidence-based practices, education and outreach has continued to produce steady gains in reducing opioid over-use.

Despite this progress, Calvert County is eighth in the state for opioid deaths as a percent of the population. According to the Calvert County Health Department, *every 11 days there is an overdose death in our community.* In 2019, the average age of those who died was 34 and it is believed half of those who died had children at home.

"We quickly realized that in order to tackle the problem in a comprehensive way, we needed all stakeholders to be involved," said **Dr. Stephanie Dubulis**, Chair Department of Emergency Medicine.

"We can get blinded by statistics, but this is a human story, not just a human health crisis," said **Dr. Drew Fuller**, former assistant director of CalvertHealth's Emergency Department (ED). "We need all-hands-on-deck and we need transformational approaches."

After working on the CalvertHealth task force, Dr. Fuller transitioned to the Calvert County Health Department as medical director for the Mobile Crisis Team, which consists of a physician/nurse practitioner, a nurse, a licensed counselor and a peer counselor. Working with the hospital and first responders, the team engages persons with opioid crisis throughout the county

Emerging Problem Identified

"We were seeing a dramatic increase in overdose-related deaths and injuries as well as narcotic-dependent behavior in patients that were coming into the ED and community practices," said Dr. Fuller.

"We didn't know how to start the discussion or who should be involved, but we knew, as a community hospital, we had to do something about the overdose deaths," said CalvertHealth Pharmacy Director, **Kara Harrer, PharmD**.

What evolved from that first meeting in 2015 was the Opioid Stewardship Task Force encompassing a multidisciplinary committee from CHMC as well as representatives from the Calvert County Health Department.

Setting Goals and Protocols

The task force set goals in 2016 to formalize opioid prescribing policy and guidelines, promote alternatives to opioids, work to become a 'Dilaudid®-free ED,' track and report prescribing practices, and develop a referral network for persons with opioid misuse disorder.

When used appropriately, opioids provide pain relief by altering the way normal healthy nerves process pain. Unfortunately, opioids change the chemistry of the brain and lead to drug tolerance. If used for an extended period of time, opioids produce dependence such that when people stop taking them, they have physical and psychological symptoms of withdrawal.

"We went from 'What can we do as a hospital?' to 'How can we partner with everyone in our community?'"

– Kara Harrer, PharmD, CHMC Director of Pharmacy Co-Chair of Opioid Stewardship Task Force

"The great majority of people who develop an opioid addiction start with pills," according to Dr. Fuller. "We felt it was our duty to make sure we were using the best evidence-based practices for prescribing opioids and that we had the highest level of accountability, which is why we adopted protocols and committed ourselves to measurement and to transparency."

"If we can avoid the possibility of patients becoming dependent on opioids, then we will see a decrease in the misuse of opioids, fewer overdoses and deaths," said Dr. Harrer.

Reducing Opioids in the ED

When the task force looked at data from the first year, they realized their plan to address the over-use of opioids was working – and continues to work. By educating doctors and nurses on pain management alternatives, the ED has:

- Reduced intravenous Dilaudid® orders by 94 percent
- Decreased the number of prescriptions written for controlled substances by 95 percent
- Decreased the number of opioid prescribing exceeding three days by 95 percent

"When people come to the ER in severe pain – of course our doctors and nurses work to get their pain under control as quickly and safely as possible and that may be through use of opioids," said Dr. Dubulis. "If a patient needs continued access to pain relief while at home, we try to limit doses for just the period of time until they can get in to see their doctor or specialist."

Addressing Patients Who Are Opioid Dependent

Equally important to reducing opioids prescribed by physicians, the Stewardship Team looked at protocols to address patients who arrived in the ED or other CalvertHealth System locations with an opioid dependence.

According to Dr. Dubulis, the Stewardship Team worked to lay the infrastructure for trying to help substance abuse patients before they were discharged.

"That infrastructure includes education, empathy, NARCAN® kits, peer counselors and getting them set up with the health department that day or the next day," Dr. Dubulis said.

Unlike a patient who is treated in the ED and told to follow up with their primary care physician within 10 days, opioid-dependent patients don't have 10 days to wait for follow-up treatment. There is a near 100-percent certainty that if these patients are not in treatment within 24 hours, they will use again, according to Dr. Fuller.

From Emergency Response to Treatment to Recovery

The Task Force developed protocols in line with the Substance Abuse and Mental Health Sciences Administration (SAMHSA) of the National Institutes of Health.

"It has been shown that if someone in crisis gets a dose of a medication-assisted treatment (MAT) in the ED, meets with a peer counselor and is linked up with a MAT provider such as the health department, they are twice as likely to follow up and stay in a recovery program," said Dr. Fuller.

"A peer counselor is not some judgmental person coming in to fix someone, and is not even a social worker. He or she is someone who has been down the same road, and has been through multiple treatment facilities – sometimes multiple treatment options – until they have been successful in overcoming opioid addiction, and now, they want to help others understand treatment options so they can be successful, too," said Dr. Dubulis.

Peer counselors can usually get to the ED in less than an hour but patients have to want to see a counselor. According to Dr. Harrer, the percentage of patients who accept being seen by a peer counselor has risen, and this is great news because it shows that patients want help before they are discharged, she said.

MAT is shown to decrease deaths by 80 percent and the Calvert County Health Department has tripled its capacity in the last two years to take care of MAT patients.

"There is close collaboration between the health department and ED. We can see people the same day in the health department or the following morning seven days a week," said Dr. Fuller.

Continued Education and Outreach

One of the initial goals of the Stewardship Team was to serve as a resource – locally, statewide and nationally – by engaging in outreach and education opportunities. To that end, education initiatives started within the Emergency Department will continue and will expand to all areas of the CalvertHealth System, and to local physician and dental practices. A sheriff's department representative has been added to the task force to provide input on trends and what law enforcement is seeing outside of the county.

"All of these efforts are to continue the robust collaboration we started in Calvert County and show how the successes we've had can be possible throughout the state and the nation," said Dr. Harrer.

The Opioid Stewardship Task Force is a multidisciplinary committee with representatives from CHMC, the Calvert County Health Department and the Calvert County Sheriff's Office.

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Agency Assistance & Acknowledgements

Maryland
DEPARTMENT OF HEALTH

Maryland Institute for
Emergency Medical Services Systems

CALVERT COUNTY
MEDICAL
RESCUE
EMERGENCY SERVICES

U.S. JUSTICE DEPARTMENT
DRUG ENFORCEMENT ADMINISTRATION

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COVID Toll

Share Tweet + Find a doctor

Aug. 4, 2020 by Health News Team

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Big Picture

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Engagement Stats

(July 2020- March 2021)

- 334 Consented Encounters ≠ Tx Encounter
  - 93 Mobile Van
  - 241 Office
- 204 Tx Encounters
- Follow Up Rate from Tx Encounters
  - 1st follow up (48 hours) – 87%
  - Remain in care (6months) – 74%

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Key Takeaway Points

- Treatment on demand –
  - Avoiding delays for OUD and other key disorders
  - Sequential evaluation process, Brief → Comp.
- Expanded Access
  - Extended hours
  - Telehealth
  - Mobile outreach component
- Teams with high level of empathy
- Community stakeholder collaboration

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References

- D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313(16):1636-1644. doi:10.1001/jama.2015.3474

CALVERT COUNTY HEALTH DEPARTMENT

Contacts

Drew Fuller, MD, MPH, FACEP

Medical Director

Drew.Fuller@Maryland.gov

Denise Dickerson, MS, LCADC, LCPC

Program & Clinical Supervisor

Denise.Dickerson@Maryland.gov

Jason Phelan, BA

Supervisor of Crisis Response Coordination

Jason.Phelan@Maryland.gov

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